Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INDUSTRIAL SOLUTIONS NETWORK
PO BOX 30969
PHOENIX AZ 85046-0969

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-1866-01

MFDR Date Received
JANUARY 30, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are claims & medical records for [injured employee], Dates of Service 10/17/2011 – 12/14/2011 have not been paid. Gerald Arceneaux; Adjuster for Gallagher Basset Insurance Company Authorized 24 visits total. The first 12 visits 10/17/201 – 11/15/2011. (Authorized on 10/06/2011) The second set of 12 visits 11/16/2011 – 12/14/2011. (Authorized on 11/20/2011). Our office called and spoke to 'Pam' at Gallagher Bassett on 12/13/2011 regarding a denial for Date of Service 10/17/2011. Pam stated, 'Denied in Error', being reprocessed. Please allow 10-15 business days. Ref #135949790. To this date, I have received no payments. I am still receiving denials."

Amount in Dispute: $3,562.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medical bill(s) made the basis of this Medical Fee Dispute have been sent back the bill audit vendor for payment. EOBs and evidence of payment will be filed with the Requestor and dWC once they are available."

Response Submitted by: Pappas & Suchma, PC, PO Box 66655, Austin, TX 78766

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 17, 2011 through December 14, 2011	Physical Therapy Services	$3,562.78	$1,804.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of workers' compensation professional services provided on or after March 1, 2008.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits:
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - 19 – (197) Precertification/Authorization/Notification absent.
   - BL – This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments.
   - LN – This line was included in the econsideration [sic] of this previously reviewed bill.
   - 12 – (125) Submission/Billing error(s).
   - 16 - Claim/service lacks information which is needed for adjudication.

Issues

1. Is the out of state provider/services eligible for Medical Fee Dispute Resolution?
2. Did the requestor obtain preauthorization?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor provided services in the state of Arizona to an injured employee with an existing Texas Workers' Compensation claim. The requestor was not satisfied with the respondent's final action. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. In accordance with 28 Texas Administrative Code §134.600(f)The requestor or employee shall request and obtain preauthorization from the carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent review shall be sent to the carrier by telephone, facsimile, or electronic transmission and, include the: (1) specific health care listed in subsection (p) or (q) of this section; (2) number of specific health care treatments and the specific period of time requested to complete the treatments; (3) information to substantiate the medical necessity of the health care requested; (4) accessible telephone and facsimile numbers and may designate an electronic transmission address for use by the carrier; (5) name of the provider performing the health care; and (6) facility name and estimated date of proposed health care.

   The insurance carrier denied some services using denial code 19 – (Precertification/Authorization/Notification absent." According to the requestor's position summary "Gerald Arceneaux; Adjustor for Gallagher Bassett Insurance Company Authorized 24 visits total."

   Review of the submitted documentation finds the first twelve (12) visits were preauthorized by Jeannie Craig RN, Medical Case Manager for GENEX Services, Inc. on October 12, 2011. Therefore, dates of service October 17, 2011 through November 16, 2011 will be reviewed in accordance with Division Rules and the Texas Labor Code.

   A preauthorization approval was not submitted for dates of service November 17, 2011 through December 14, 2011; therefore, in accordance with 28 Texas Administrative Code §134.600(f) these dates of service are not eligible for review. As a result the amount ordered is $0.00.

3. Per 28 Texas Administrative Code §134.203(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1)Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules; and (c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   In accordance with 28 Texas Administrative Code §134.203(b) CPT Code 97010 – Hot/Cold Pack – is considered a bundled code and not reimbursable. As a result the amount ordered is $0.00.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007.

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) x Participating Amount = Maximum Allowable Reimbursement (MAR). The 2011 DWC conversion factor for this service is 54.54; the Medicare conversion factor is 33.9764.

   - CPT Code 97110 – (54.54÷33.9764) x $28.74 = $46.13 x 25 units = $1,153.25. The requestor billed a total of $1,025.00 - $82.00 (payment) = $943.00
   - CPT Code 97140 – (54.54÷33.9764) x $27.10 = $43.50 x 12 units = $522.00. The requestor billed a total of $492.00 - $41.00 (payment) = $451.00
   - CPT Code 97035 – (54.54÷33.9764) x $11.62 = $18.65 x 12 units = $223.80. The requestor billed a total of $149.50 - $11.50 (payment) = $138.00
   - CPT Code 97033 – (54.54÷33.9764) x $27.09 = $43.49 x 9 units = $391.41. The requestor billed a total of $306.00 - $34.00 (payment) = $272.00
   - The requestor billed CPT Code 97014 on October 31, 2011 and November 2, 2011. Medicare does not price this code; therefore, this code will be reviewed in accordance with 28 Texas Administrative Code §134.1(e) Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:(3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section. According to subsection (f)Fair and reasonable reimbursement shall:(1)be consistent with the criteria of Labor Code §413.011; 2)ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3)be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available. Review of the submitted documentation finds the requestor did not provide documentation to support how it determined its usual and customary charges for the disputed services; documentation of the comparison of charges to other carriers was not presented for review; or documentation of the amount of reimbursement received for these same or similar services was not presented for review. As a result the amount ordered is $0.00
   - The requestor billed CPT Code 97001 on October 17, 2011 and CPT Code 97002 on November 2, 2011. Review of the EOBs finds the insurance carrier reimbursed these two codes in accordance with 28 Texas Administrative Code §134.203. As a result the amount ordered is $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,804.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,804.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		April 4, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.